



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1659-N]

RIN 0938-ZB26

Medicare Program; Explanation of FY 2004 Outlier Fixed-Loss Threshold as Required by Court Rulings

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Clarification.

SUMMARY: In accordance with court rulings in cases that challenge the federal fiscal year (FY) 2004 outlier fixed-loss threshold rulemaking, this document provides further explanation of certain methodological choices made in the FY 2004 fixed-loss threshold determination.

DATES: [Insert date of publication in the Federal Register].

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

On May 19, 2015, the Court of Appeals for the District of Columbia (D.C.) Circuit issued a decision in *District Hospital Partners, L.P. v. Burwell*, 786 F.3d 46 (D.C. Cir 2015) (*District Hospital Partners*), holding that the FY 2004 outlier fixed-loss threshold was inadequately explained in the FY 2004 Inpatient Prospective Payment Systems (IPPS) final rule. The court of appeals instructed the district court to remand to the Secretary of Health and Human Services (the Secretary) for further explanation of the Secretary's handling of data pertaining to 123

hospitals that the Secretary had described in a proposed rule updating the outlier regulations (the outlier proposed rule) as hospitals likely to have manipulated their charges to maximize their outlier payments. The court of appeals specified--

On remand, the Secretary should explain why she corrected for only 50 turbo-charging hospitals in the 2004 rulemaking rather than for the 123 she had identified in the NPRM. She should also explain what additional measures (if any) were taken to account for the distorting effect that turbo-charging hospitals had on the dataset for the 2004 rulemaking. And if she decides that it is appropriate to recalculate the 2004 outlier threshold, she should also decide what effect (if any) the recalculation has on the 2005 and 2006 outlier and fixed loss thresholds.

District Hospital Partners, 786 F.3d at 60. The District Court for the District of Columbia, in turn, issued a remand order to the Secretary. (See *District Hospital Partners, L.P. v. Burwell*, No. 11-cv-116 (ECF 129) (August 13, 2015).)

On September 2, 2015, the District Court for the District of Columbia issued an opinion and order in a separate case, *Banner Health v. Burwell*, No. 10-cv-1638 (ECF 149 and 150) (*Banner Health*), remanding the fixed loss outlier threshold from the FY 2004 IPPS final rule for additional explanation consistent with the *District Hospital Partners* case. The court stated that the agency should “explain further why it did not exclude the 123 identified turbo-charging hospitals from the charge inflation calculation for FY 2004—or ... recalculate the fixed loss threshold if necessary.” (*Banner Health Memorandum Opinion* (ECF 150) at p.107 and p.120.) We are issuing this document to provide the additional explanation required by these decisions.

II. Provisions of the Notice

A. The Rulemaking at Issue

The Medicare statute requires that outlier payments be calculated based on charges, adjusted to cost (see 42 U.S.C. 1395ww(d)(5)(A)(ii)). To compute an outlier payment, we use hospital-specific cost-to-charge ratios (CCRs), calculated from historical cost and charge data, to

reduce the charge on the claim to a cost estimate. The estimated costs of the case are then compared to the Diagnosis Related Group (DRG) payment plus the fixed loss outlier threshold to determine if an outlier payment is appropriate and, if so, the amount of any such payment. Thus, CCRs play a significant role in determining the outlier payment for a case.

In the March 5, 2003, **Federal Register** (68 FR 10420), we issued a proposed rule (the outlier proposed rule) that would update the outlier regulations due to improper manipulation of charges by hospitals, also known as “turbocharging.” On June 9, 2003, we issued a subsequent final rule (68 FR 34494) that finalized changes to the outlier policy (the outlier final rule). In the FY 2004 IPPS final rule, which appeared in the August 1, 2003, **Federal Register** (68 FR 45346) (the FY 2004 IPPS final rule), we applied the policies finalized in the outlier final rule in the calculation of the FY 2004 fixed loss outlier threshold.

In the outlier proposed rule, we proposed multiple policy changes that affected outlier payments. These policies were finalized in the outlier final rule. The changes were intended to respond to turbocharging, a practice in which hospitals would repeatedly increase their charges at rates exceeding the rates of increase in their costs. Turbocharging would lead to outlier payments greater than warranted by a hospital’s actual costs because the historical CCR used to generate cost estimates would not capture the true present relationship between the hospital’s costs and its charges.

Three specific changes made in the outlier final rule are relevant to our present discussion. The first important change made in the outlier final rule was to alter our policy regarding when to apply statewide average CCRs. Prior to the outlier final rule, when a hospital’s CCR dipped below a pre-determined CCR floor (set in the annual IPPS final rule), it would be assigned a statewide average CCR in place of the hospital’s computed CCR. We noted

that if a hospital repeatedly increased its charges at a faster rate than its costs increased, its CCR could fall below the floor, which would lead to the application of a higher statewide average CCR, and would significantly increase outlier payments. Therefore, in order to mitigate gaming of the application of the statewide average CCR, we finalized a policy that would no longer substitute statewide average CCRs if a hospital's actual CCR dipped below the floor. Hospitals would be assigned their actual CCRs no matter how low their CCR dipped.

The second key change to the outlier policy was to require use of CCRs from tentative settled Medicare cost reports when available. Previously, a hospital's outlier payments would be calculated based on a CCR drawn from its most recent final settled cost report, that is, its most recent cost report that had undergone complete review. We observed that if a hospital had significantly increased its charges since the period covered by its most recent final settled cost report, the hospital could receive inordinately high outlier payments because the CCR used to calculate its payments would not reflect its recent charge increases. Therefore, we modified the outlier policy to require use of more up-to-date CCR data drawn from a tentative settled cost report, when available. The tentative settlement is a cursory review of the cost report that takes place within 60 days of the acceptance of a cost report by CMS. We explained that we expected use of this more up-to-date data would reduce the time lag between a hospital's CCR and its current billed charges by a year or more. In our discussion of this policy change in the March 2003 outlier proposed rule, we described an analysis of the Medicare Provider Analysis and Review (MedPAR) file data from FY 1999 to FY 2001 in which we identified 123 hospitals whose percentage of outlier payments relative to total DRG payments increased by at least 5 percentage points over that period, and whose case-mix (the average DRG relative weight value for a hospital's Medicare cases) adjusted charges increased at a rate at or above the 95th

percentile rate of charge increase for all hospitals (46.63 percent) over the same period. We noted at that time that the recent dramatic increases in charges for those hospitals were not reflected in their current CCRs (based on final settled cost reports).

The third key change made in the outlier final rule was to make outlier payments subject to adjustments when hospitals' cost reports are settled. We explained that outlier payments would be processed throughout the year using operating and capital CCRs based on the best information available at that time, but at the time a cost report was settled, outlier payments could be reconciled using updated CCRs that are computed from more recent cost report and charge data. We instructed our contractors to put a hospital through outlier reconciliation if it: 1) has a 10-percentage point change in its CCR from the time the claim was paid compared to the CCR at final cost report settlement; and 2) receives total outlier payments exceeding \$500,000 during the cost reporting period.

Some of the provisions of the outlier final rule became effective for discharges occurring on or after August 8, 2003. The remaining provisions became effective for discharges occurring on or after October 1, 2003.

After these changes were finalized in the June 2003 outlier final rule, we then set the fixed loss outlier threshold for FY 2004 in the FY 2004 IPPS final rule (68 FR 45476 through 45478). When we calculated the fixed-loss threshold for FY 2004, we simulated payments by applying FY 2004 rates and policies to cases from the FY 2002 MedPAR file. The FY 2004 policies applied in the payment simulations included the policy changes that had been finalized in the June 2003 outlier final rule: 1) we attempted to approximate the use of tentative settled cost report data by calculating updated cost-to-charge ratios for each hospital from recent cost reporting data; and 2) we used a hospital's computed

CCR even if it was very low, rather than substituting a statewide average CCR. We noted that it was difficult to project which hospitals would be subject to reconciliation of their outlier payments using then-available data. Nevertheless, we stated that our analysis at that time had identified approximately 50 hospitals that we thought would be subject to reconciliation. For those approximately 50 hospitals, we employed cost-to-charge ratios estimated from recent data using the hospital's rate of increase in charges per case based on FY 2002 charges, compared to costs (inflated to FY 2004 using actual market basket increases).

B. Further Explanation of the FY 2004 Determination in Response to the Courts' Orders

The court rulings discussed previously stated that we should explain why, in simulating FY 2004 payments to calculate the FY 2004 fixed loss outlier threshold, we made additional adjustments to the cost-to-charge ratios for approximately 50 hospitals, given that the March 2003 outlier proposed rule had discussed 123 hospitals that appeared to have benefited from vulnerabilities in the outlier payment rules. The reason is that the adjustments made to approximately 50 hospitals were intended to account for changes that might be made to hospitals' cost-to-charge ratios through reconciliation when their cost reports were settled. Those particular adjustments were not intended to account for possible disparities between hospitals' historical cost-to-charge ratios and the ratios that would be used to calculate FY 2004 outlier payments at the time the hospitals' claims were processed. We had separately accounted for disparities of that kind by computing new cost-to-charge ratios for all hospitals, including the 123 hospitals previously identified as possible turbochargers.

As discussed previously, our June 2003 outlier final rule was motivated by our observation that, because of turbocharging, the cost-to-charge ratios used to calculate a hospital's outlier payments sometimes failed to reflect the actual relationship between the hospital's costs

and its charges at the time the hospital submitted a claim for payment. The June 2003 outlier final rule included separate measures that were each designed to address a different component of this problem. We adopted the use of more up to date cost-to-charge ratio data from tentative settled cost reports to ensure that the cost-to-charge ratio used to make a hospital's payments would come as close as possible to reflecting the present relationship between the hospital's costs and its charges. However, we recognized that while using data from tentative settled cost reports would reduce the time lag between cost-to-charge ratio data and outlier payment claims, it would not eliminate the time lag altogether. Data from a tentative settled cost report still would not reflect recent charge increases that had occurred since the submission of the cost report. Therefore, we separately provided for reconciliation of outlier payments at the time a cost report was settled. Thus, if a hospital received unduly high outlier payments because it had significantly increased its charges since the time of its most recent tentative settled cost report, there would be some opportunity to readjust those payments at a later date based on even newer data.

To simulate FY 2004 payments for purposes of calibrating the FY 2004 fixed loss outlier threshold, we needed to apply the rules that would be in place in FY 2004, and so we needed to simulate application of the new rules that had been adopted as part of the June 2003 outlier final rule. To approximate the use of more recent data from tentative settled cost reports, we calculated cost-to-charge ratios from more recent data for all hospitals, including the 123 hospitals discussed in the March 2003 proposed rule. Our most immediate purpose in this measure was to ensure that our simulated FY 2004 payments would match up as closely as possible with how FY 2004 claims would actually be paid. But this measure also had the additional benefit of reducing any reason for concern that cost-to-charge ratios drawn from older

historical data for the 123 hospitals would not reliably approximate the cost-to-charge ratios that would be used to pay FY 2004 claims for those 123 hospitals. The payment simulations employed cost-to-charge ratios calculated from very recent data for all hospitals, including the 123 hospitals, and did not employ cost-to-charge ratios drawn from older historical data.

The additional adjustments made to approximately 50 hospitals were intended to simulate the operation of the newly adopted rule permitting some outlier payments to be adjusted through reconciliation after they were paid. Reconciliation of outlier payments is a burdensome process, and we had indicated that reconciliation would not be performed for all hospitals, or even all hospitals suspected of turbocharging in the past. Rather, reconciliation generally would be performed only if a hospital met the criteria we had specified for reconciliation: a 10-percentage point change in the hospital's CCR from the time the claim was paid compared to the CCR at cost report settlement; and receipt of total outlier payments exceeding \$500,000 during the cost reporting period. We identified approximately 50 hospitals that we determined likely to meet these criteria in FY 2004, and we specially calculated cost-to-charge ratios for those hospitals as explained previously and in the FY 2004 IPPS final rule, so that our payment simulations would represent our best approximation of the final amount of outlier payments after reconciliation had been completed. We did not expect that all of the 123 hospitals discussed in the March 2003 proposed rule would be likely to meet the criteria for reconciliation, and so we did not make this same adjustment with respect to all of those 123 hospitals.

The court rulings also called for an explanation of other steps taken to account for any "distorting effect" associated with the 123 hospitals discussed in the March 2003 proposed rule. As we explained previously, our payment simulations employed cost-to-charge ratios calculated from recent data for all hospitals, including the 123 hospitals, and did not employ cost-to-charge

ratios drawn from older historical data. That reduced any reason for concern that cost-to-charge ratios drawn from older historical data for the 123 hospitals would not reliably approximate the cost-to-charge ratios that would be used to pay FY 2004 claims for those 123 hospitals. We also anticipated that implementation of the June 2003 outlier final rule would curb the turbocharging practices that had caused rapid increases in charges in previous years; and therefore, we saw no reason to further adjust our payment simulations to account for future turbocharging by the 123 hospitals. Therefore, we did not apply any additional adjustments focused on the 123 hospitals that had been discussed in the March 2003 proposed rule, beyond the adjustments we have already discussed.

The court rulings also stated that we should explain further why we did not exclude the 123 identified turbo charging hospitals from the charge inflation calculation for FY 2004. We simply did not have strong reason to believe that excluding the 123 hospitals from the charge inflation calculation, or from other parts of the fixed loss outlier threshold calculation, would improve our projections.

When we simulate payments for purposes of calculating the fixed loss outlier threshold, we use MedPAR data from an earlier period to produce a simulated set of claims for the period for which we are calculating the fixed loss outlier threshold. For the FY 2004 final rule, we used cases from the FY 2002 MedPAR file to simulate FY 2004 cases. We applied a charge inflation factor to account for growth in hospital charges between the period covered by the MedPAR data and the period for which we are calculating the fixed loss outlier threshold. In this instance, the charge inflation factor was intended to account for growth in hospital charges over the 2-year period between FY 2002 and FY 2004. We estimated charge growth over this period based on actual charge growth over an earlier 2-year period, FY 2000 to FY 2002. More specifically, our

estimate of charge inflation was based on the 2-year average annual rate of change in charges per case from FY 2000 to FY 2001 and from FY 2001 to FY 2002 (12.5978 percent annually, or 26.8 percent over 2 years).

Although we expected the June 2003 outlier final rule to curb turbocharging, which would affect the rate of charge growth after the rule became effective, we believed that past charge growth would still be a satisfactory basis for estimating more recent charge growth, for the 123 hospitals as well as for other hospitals. The outlier final rule was in effect for only part of the interval that our charge inflation estimate was intended to reflect. The outlier final rule went into effect only in part for the last 2 months of FY 2003, and went into effect in full only at the beginning of FY 2004.

We had no strong reason to expect that excluding the 123 hospitals from our charge inflation calculations, or from other parts of our simulations, would improve our simulations in a way that would bring outlier payments closer to our target of 5.1 percent of operating DRG payments. The 123 hospitals were not excluded from claiming outlier payments in FY 2004, so excluding them from our simulations would have introduced a different form of distortion into our simulations, by causing the simulations to disregard the impact of those hospitals. While excluding the 123 hospitals might produce a lower estimate of charge inflation, a lower estimate is not necessarily a better estimate. A charge inflation estimate that is too low could lead to a fixed loss outlier threshold that produces outlier payments farther from, instead of closer to, the target of 5.1 percent of operating DRG payments.

Finally, the court rulings state that if we decide to recalculate the FY 2004 fixed loss outlier threshold, we should also address any effect that recalculation has on the FY 2005 and FY 2006 outlier and fixed-loss thresholds. We are not recalculating the FY 2004 fixed-loss

threshold. We also note that the fixed loss outlier thresholds are set based on new calculations each year without reference to the previous year's threshold; even if the FY 2004 threshold had been reset, there would be no reason to revisit the FY 2005 or FY 2006 calculation.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

CMS-1659-N

Dated: January 4, 2016

Andrew M. Slavitt,
Acting Administrator,
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Approved: January 15, 2016

Sylvia M. Burwell,
Secretary,
Department of Health and Human Services.

BILLING CODE 4120-01-P

[FR Doc. 2016-01309 Filed: 1/21/2016 8:45 am; Publication Date: 1/22/2016]